Case No. 08-2033

UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

DAVID B. COX,

Plaintiff-Appellant,

v.

STANDARD INSURANCE COMPANY
and BON SECOURS – COTTAGE
HEALTH SERVICES GROUP PLAN,

Defendants-Appellees.

On Appeal From The United States District Court
For The Eastern District Of Michigan
Hon. Anna Diggs Taylor
No. 2:07-cv-13304

BRIEF OF DEFENDANTS-APPELLEES STANDARD INSURANCE COMPANY AND BON SECOURS – COTTAGE HEALTH SERVICES GROUP PLAN

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UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

DAVID B. COX,	)	
	)	
Plaintiff - Appellant,	)	**U.S. District Court for**
	)	**Eastern District of Michigan**
	)	
	)	**No. 2:07-cv-13304**
v.	)	
	)	**Judge Anna Diggs Taylor**
STANDARD INSURANCE COMPANY;	)	
BON SECOURS-COTTAGE HEALTH	)	
SERVICES GROUP PLAN,	)	
	)	
Defendants - Appellees.	)	

DEFENDANTS' CIRCUIT RULE 26.1 CORPORATE DISCLOSURE STATEMENT

The following information is submitted pursuant to Cir. R. 26.1 and Fed. R. App. P. 26.1:

1. Is said party a subsidiary or affiliate of a publicly owned corporation? Yes. If yes, list the identity of the parent corporation or affiliate and the relationship between it and the named party: StanCorp Financial Group, Inc.; Standard Insurance Company is a subsidiary of StanCorp Financial Group, Inc.

2. Is there a publicly owned corporation, not a party to the appeal, that has a financial interest in the outcome? If yes, list the identity of such corporation and the nature of the financial interest: StanCorp Financial Group, Inc.; Standard Insurance Company is a subsidiary of StanCorp Financial Group, Inc.

Respectfully submitted,

By: /s/ Warren S. von Schleicher
Attorney for Defendants, Bon Secours Cottage Health Services Group Plan and Standard Insurance Company

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STATEMENT IN SUPPORT OF ORAL ARGUMENT

Oral argument is requested. Defendants-Appellees, Standard Insurance Company and Bon Secours – Cottage Health Services Group Plan, request oral argument in order to address any questions the panel of the United States Court of Appeals for the Sixth Circuit might have regarding the facts and applicable law.

JURISDICTIONAL STATEMENT

The Jurisdictional Statement of the Plaintiff-Appellant, David B. Cox, is complete and correct.

STATEMENT OF THE ISSUES

Whether the benefit eligibility determination of Standard Insurance Company, as the claims administrator for Bon Secours – Cottage Health Services Group Plan, to decline David B. Cox's claim for long-term disability benefits under the Employee Retirement Income Security Act of 1974, 29 U.S.C. §1001 *et. seq.* ("ERISA") was reasonable and permissible, and not arbitrary and capricious.

STATEMENT OF THE CASE

The Plaintiff-Appellant, David B. Cox ("Cox"), was a participant in the Bon Secours – Cottage Health Services Group Plan ("Plan"), which is an employee welfare benefit plan established by Cox's former employer, Bon Secours – Cottage Health Services ("Bon Secours"). Bon Secours provided its employees with short-term disability coverage under its employer funded short-term disability plan

("STD Plan"). Bon Secours retained the final authority to decide eligibility for short-term disability benefits under the STD Plan. (R 16; ROA 1375).[1]

In addition, Bon Secours provided its employees with long-term disability coverage under its insurer funded long-term disability plan ("LTD Plan"). The LTD Plan was funded through a group long-term disability insurance policy ("Group Policy") issued to Bon Secours by Standard Insurance Company ("Standard"). It is undisputed that the Group Policy grants discretionary authority to Standard, and that Standard's benefit decision was properly reviewed by the district court pursuant to the arbitrary and capricious standard.[2]

On May 21, 2003, Cox submitted a claim for disability benefits under the Plan. Cox received short-term disability benefits under the STD Plan from May 7, 2003 through October 28, 2003, and long-term disability benefits under the LTD Plan through March 31, 2006. (R 16; ROA 1286; ROA 687). Standard declined to

[1] Citations to "R _" are to the civil docket record entry number of the U.S. District Court for the Eastern District of Michigan. Citations to "ROA _" are to the corresponding page of the Record on Appeal. Citations to "App. Br., pg. _" are to the corresponding page of Plaintiff-Appellant's Brief on Appeal.

[2] The Group Policy provides a maximum 24 month benefit period if a Plan participant becomes disabled from working in his "Own Occupation." After 24 months, the participant must establish that he is "unable to perform with reasonable continuity the Material Duties of Any Occupation." (R 16; ROA 1397, 1402 to 1403).

pay long-term disability benefits to Cox after March 31, 2006. Cox exhausted his administrative remedies under ERISA on June 6, 2007. (R 16; ROA 82 to 68).

On August 8, 2007, Cox filed a Complaint in the U.S. District Court for the Eastern District of Michigan seeking long-term disability benefits under §502(a)(1)(B) of ERISA, 29 U.S.C. §1132(a)(1)(B). On December 7, 2007, Cox filed an Amended Complaint seeking benefits under §502(a)(1)(B). The parties subsequently filed cross motions for judgment on the administrative record.

On July 14, 2008, after oral argument, the district court granted the Plan's and Standard's motion for judgment. On July 22, 2008, the district court entered final judgment for the Plan and Standard pursuant to Fed. R. Civ. P. 54. On August 4, 2008, Cox filed a timely Notice of Appeal. Jurisdiction of the United States Court of Appeals for the Sixth Circuit is based on 28 U.S.C. §1291 and Rules 3 and 4 of the Federal Rules of Appellate Procedure.

STATEMENT OF FACTS

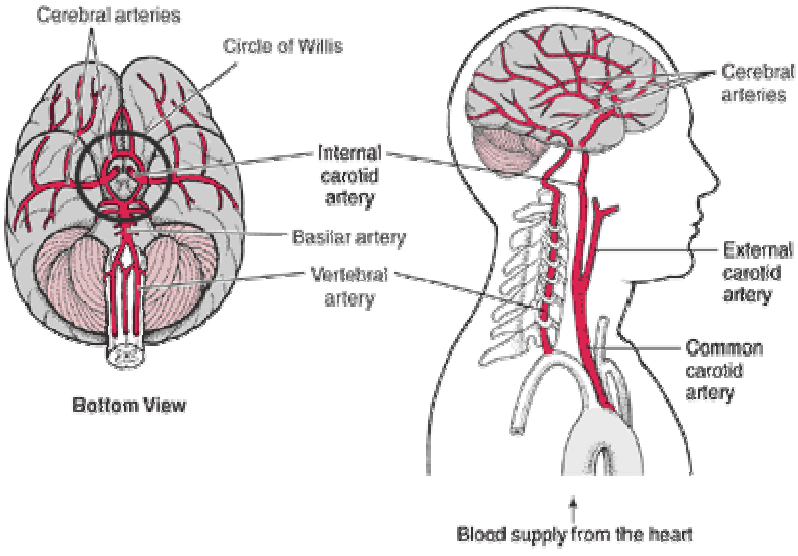
Cox was employed by Bon Secours as a general practice physician. As a general practice physician, Cox provided patient care, conducted medical research, and had limited teaching responsibilities. (R 16; ROA 1337).

On May 21, 2003, Cox submitted a disability claim to Standard, in which he claimed to be disabled since April 29, 2003 due to "vertebral artery thrombosis," "vertebral basilar ischemia" and "complicated migraine." (R 16; ROA 1379).

Standard also received an Attending Physician Statement ("APS") signed by Cox's treating neurologist, James Voci, MD. On the APS, Dr. Voci noted Cox's diagnosis as "complicated migraine" and "vertebrobasilar thrombosis/ischemia." (R 16; ROA 1380).

Nature Of Cox's Claimed Medical Condition

Ischemia occurs when the blood flow in an artery or vessel is restricted, causing tissue damage or dysfunction. See http://en.wikipedia.org/wiki/Ischemia. Thrombosis occurs when a blood clot forms in an artery or blood vessel restricting the blood flow. See http://www.medterms.com/script/main/art.asp?articlekey =25023; *Steadman's Medical Dictionary*, 3rd ed. (1972). In the present case, Dr. Voci diagnosed Cox with ischemia and thrombosis in the vertebral and basilar arteries of the brain. These arteries are depicted in the following diagrams:



See http://www.merck.com/media/mmhe2/figures/fg086_1.gif.

Cox's Short-Term Disability Claim

On May 30, 2003, Cox told a Standard claims representative that he experienced "disabling" migraine headaches "about every other day," he was taking blood thinners to treat a blood clot in his brain, and that his doctor did not think he would be able to return to work within the next month. (R 16; ROA 1335). On June 5, 2003, Standard informed Cox that his short-term disability claim had been approved. As the rationale for approving benefits, Standard explained that Bon Secours "is responsible for funding the benefits payable under the plan and has the right of final review and decision on your claim." (R 16; ROA 1375).

On June 6, 2005, Standard received a note from Cox's neurologist, Dr. Voci, written on prescription pad paper, stating:

> Due to ongoing illness + MRI evidence for ischemic damage in the brainstem + cerebellum, I am continuing medical disability until July 15. He [Cox] may perform lectures for now, but not office work, until further notice.

(R 16; ROA 1377). Based on Dr. Voci's note, Standard approved payment of short-term disability benefits through July 15, 2003. (R 16; ROA 1369 to 1368). Standard subsequently extended the payment of benefits while continuing to evaluate Cox's disability claim.

On August 5, 2003 and August 7, 2003, Dr. Voci's office submitted eight pages of documents to Standard, consisting of a second APS dated June 17, 2003, a

"To whom it may concern" letter dated July 21, 2003, a medical chart note from a June 5, 2003 office visit, and a note written on prescription pad paper reiterating Cox's restrictions and limitations. (R 16; ROA 1361 to 1354; ROA 1353 to 1352; ROA 1339).

On August 7, 2003, Standard consulted a physician of internal medicine, Bradley Fancher, MD, who reviewed Dr. Voci's limited records. Accepting Dr. Voci's diagnosis of vertebral-basilar ischemia at face value, Dr. Fancher opined that it was reasonable that Cox would be unable to work for a period of up to six months. (R 16; ROA 1349). Bon Secours paid short-term disability benefits to Cox from May 7, 2003 through October 28, 2003. (R 16; ROA 1348 to 1347).

Cox's "Own Occupation" Long-Term Disability Claim

On September 18, 2003, Standard requested all of Cox's medical records from Dr. Voci, including "[a] copy of all clinical records (chart notes, health history statements, lab/x-ray/scan results, consult reports, referrals, [and] other insurance information)" from "January 1, 2002 to Present." (R 16; ROA 1346). In response to Standard's request, Dr. Voci produced only 16 pages of medical records.

In addition, on September 30, 2003, a representative of Standard interviewed Cox about his claimed medical condition. Cox informed Standard that he sustained a stroke in his brainstem and cerebellum on April 29, 2003. (R 16; ROA

1327; R. 15; ROA 16, ¶ 7). According to Cox, "all of his physicians" told him that he is "lucky to be alive." (R 16; ROA 1327). Cox told Standard that, as a result of his stroke, he experiences ongoing symptoms of severe dizziness, difficulty walking, fatigue and memory loss. (R 16; ROA 1327). He stated that his photographic memory was "now shot," and that tasks he used to perform in one hour now take four to five hours to perform. (R 16; ROA 1327). He stated that he experiences one headache per week, and that he no longer can take the medication he previously tool to prevent headaches (triptans) because the medication might increase the risk of stroke. (R 16; ROA 1327).

Standard again consulted Dr. Fancher, who opined that it is reasonable that Cox would be unable to work due to cognitive difficulties caused by the stroke. (R 16; ROA 1287, 1236). On October 21, 2003, therefore, Standard informed Cox that his claim for long-term disability benefits has been approved. (R 16; ROA 1274 to 1273). Standard paid benefits to Cox throughout the 24-month Own Occupation disability period, which ended on October 29, 2005.

Cox's "Any Occupation" Long-Term Disability Claim

On January 20, 2005, Standard informed Cox that to qualify for benefits after October 29, 2005, he must satisfy the Group Policy's Any Occupation definition of disability. (R 16; ROA 1112 to 1107). Standard continued to pay

monthly disability benefits to Cox while evaluating his eligibility for Any Occupation disability benefits.

On April 21, 2005, Cox informed Standard that he developed symptoms of "incredible fatigue" secondary to his stroke. Cox relayed that a sleep study performed on March 14, 2005 by Thomas Giancarlo, D.O. detected a disruption in his REM sleep cycle. (R 16; ROA 1080). In a letter to Standard, Cox attributed his sleep disorder to the secondary effects of his April 29, 2003 brainstem stroke. (R 16; ROA 1081).

Cox also submitted an updated APS signed by Dr. Voci on April 26, 2005. In the APS, Dr. Voci noted Cox's primary diagnosis as "Stroke – Brainstem CVA," and his secondary diagnosis as "Sleep Apnea / REM linked Central Sleep Dx [disorder] / Basilar Migraine." (R 16; ROA 1077). Dr. Voci opined that Cox's condition had caused "Permanent disability." (R 16; ROA 1077).

In evaluating Cox's eligibility for Any Occupation disability benefits, Standard obtained updated medical records from Dr. Voci, medical records from Bon Secours Hospital, and Dr. Giancarlo's sleep study. (R 16; ROA 1062; ROA 1056 to 1046; ROA 1037; ROA 1032 to 940) These records were reviewed by Standard's consulting physician, Dr. Fancher. (R 16; ROA 923 to 922). Dr. Fancher opined that the sleep study was essentially normal:

> The claimant had a sleep study in March 2005. A respiratory disturbance index of 4 events per hour was noted. This is

> essentially within normal limits. The claimant had a periodic limb movement arousal rate of 5 per hour, which also is quite mild.

(R 16; ROA 922). Dr. Fancher opined that Dr. Voci's opinion of permanent disability was "difficult to corroborate" with the clinical findings in the medical records. Dr. Fancher, therefore, recommended further evaluation by a medical specialist. (R 16; ROA 922).

Pursuant to Dr. Fancher's recommendation, Standard consulted Elias Dickerman, M.D., Ph.D., a Board certified neurologist and psychiatrist. Dr. Dickerman maintains an active clinical practice and serves as Clinical Professor of Neurology at the University of California Davis Medical Center. (R 16; ROA 917). Dr. Dickerman opined that Dr. Voci's diagnosis of a stroke was unsupported by the radiographic findings. Whereas Dr. Voci had described the May 31, 2003 MRI "as revealing abnormal signal of ischemia in the inferior brainstem and left cerebellar region," the actual findings on the MRI report found no evidence of ischemia. (R 16; ROA 913). As noted by Dr. Dickerman:

> The actual official report of the MRI scan of the brain with and without contrast of May 31, 2003, did not describe any specific area of focal change. In effect, there was no abnormal diffusion and no enhancement. That alone would be contrary to the report by Dr. Voci and significantly unexpected in a patient that had by history an ischemic CVA.

(R 16; ROA 914). Dr. Dickerman noted that Dr. Voci exhibited a pattern of interpreting the MRI scans as indicative of stroke, when, in fact, the radiologists who performed the MRI scans detected no evidence a stroke:

> Considering the distribution of the symptoms as recorded. The patient's angiogram with occlusion of the right vertebral artery and pica on the right would not explain the subsequent description of the MRI scan by Dr. Voci, MRI scans that clearly have been interpreted differently by the radiologist. I refer you to previous comments in which I already indicated that it would have been highly unusual to have no abnormalities with diffusion weighted MRI scans and contrasted MRI scans one month post incident if he had an actual stroke or CVA of the brainstem as described.

(R 16; ROA 915 to 914).

Dr. Dickerman concluded that Cox experiences intermittent migraine headaches, during which he experiences temporary symptoms common of migraines, but that these intermittent migraines would not render Cox permanently disabled. (R 16; ROA 916 to 915).

In order to determine whether Cox sustained any neurological deficit from a purported stroke, Standard obtained a neuropsychological IME of Cox, which was performed by Robin Hanks, Ph.D., ABCN, a Board certified neuropsychologist. Dr. Hanks serves as the director of the Southeastern Michigan Traumatic Brain Injury System and as Professor of Psychology, Physical Medicine and Rehabilitation at Wayne State University School of Medicine. (R 16; ROA 802). Dr. Hanks's extensive *curriculum vitae* is contained in the administrative record

and establishes her credentials as a leading expert in the field of neuropsychology. (R 16; ROA 802).

Dr. Hanks performed nine hours of cognitive and psychological testing over a three day period in November and December 2005. (R 16; ROA 797). The neurocognitive test results were all "within normal limits" with no evidence of impaired cognitive functioning. (R 16; ROA 800). To the contrary, Cox scored in the *superior* range of intellectual functioning: "Estimation of the examinee's intellectual functioning, placed him in the very superior range of intellectual functioning (Full Scale IQ = 130)." (R 16; ROA 798). The neuropsychological testing demonstrated that Cox had no cognitive impairment whatsoever:

> On measures of attention, language, visual spatial functioning, memory abilities, motor skills, and executive functioning, his abilities were all within expected limits. His performance on these measures were intact and there was no pattern or level of impairment noted in his cognitive profile. As such, there was no quantitative evidence of impairment on neurocognitive measures.

(R 16; ROA 799). Dr. Hanks concluded that Cox's subjective complaints of impaired memory, comprehension and organizational skills were inconsistent with the objective test results:

> Dr. Cox indicated that he had difficulty with memory, with reading comprehension, and organization. These were not consistent with his neuropsychological testing and these were not indicated in the behavioral observations during the testing.

(R 16; ROA 800).

Standard obtained surveillance of Cox's activities on December 14, 15 and 16, 2005. On December 14, 2005, Cox left his home at 11:44 am, drove his minivan in order to perform various shopping errands, and returned two hours later, at 1:45 pm. (R 16; ROA 809 to 808). On December 15, 2005 (the day of Dr. Hanks's IME), Cox was observed departing Dr. Hanks's building at 11:49 am, but rather than returning home, Cox drove to the Universal Mall in Warren, Michigan, where he shopped for chessboards. The shopping mall was illuminated with fluorescent lighting, which supposedly triggers Cox's migraines. Cox nevertheless continued shopping in the mall for nearly one hour. (R 16; ROA 814 to 812). Although the surveillance was obtained during a snow storm, Cox had no difficulty driving; indeed, he was observed talking on his cell phone while driving in the snow storm. Even though Dr. Voci had identified physical stress as a trigger for migraines, Cox also was observed shoveling snow from his driveway. (R 16; ROA 814 to 811). The DVD of the surveillance was submitted to the district court for review as part of the administrative record.

On March 23, 2006, Standard informed Cox of its decision to decline his claim for long-term disability benefits, under the Any Occupation definition of disability.

Cox's Administrative Appeal

On September 8, 2006, Cox, through his attorney, appealed Standard's claim determination. (R 16; ROA 369 to 350). Cox's attorney enclosed with the appeal a signed statement from Dr. Voci, a notice of award letter from the SSA and records from Cox's hospitalization on April 29, 2003, including the April 29, 2003 MRI report and the April 30, 2003 angiogram (which had not previously been submitted to Standard). (R 16; ROA 669 to 350).

Standard consulted Lawrence Zivin, M.D., a Board certified neurologist with thirty years experience treating patients in private practice. Dr. Zivin reviewed all of Cox's medical records contained in the administrative record, including the complete set of MRI reports and the April 30, 2003 angiogram report. (R 16; ROA 303; ROA 286 to 282). Dr. Zivin opined that Dr. Voci's diagnosis of a basilar stroke was unsupported by the radiographic evidence and, indeed, was contrary to the findings of the radiologists who evaluated the MRIs and angiogram. (R 16; ROA 283 to 282; ROA 285). Dr. Zivin determined that "Dr. Cox has not suffered clinical residua of an imputed stroke event or multiple stroke events." (R 16; ROA 301). Dr. Zivin concluded that Cox has a longstanding history of migraine headaches associated with transient symptoms typical of migraines, but that these sporadic migraines did not prevent him from working as a general practice physician. (R 16; ROA 301).

Finally, Standard learned that Cox, during his period of claimed disability, engaged in occupational activity as a "Consultant and Researcher" with his own company called Cerberus Advocacy. (R 16; ROA 270). In January 2005, Cox was a featured speaker on the issue of bipolar spectrum disorders at the annual meeting of the American Academy of Family Physicians in Orlando, Florida. (R 16; ROA 280). Cox lectured on the issue of depression on July 14, 2006 in Chicago, Illinois, and on July 28, 2006 in Raleigh, North Carolina. (R 16; ROA 274 to 271). On September 27, 2006, from 4:30 pm to 7:30 pm, Cox spoke at a symposium in Washington, D.C. on the issue of attention deficit disorder. (R 16; ROA 279). On September 30, 2006, Cox delivered a two-hour lecture in Washington on the issue of anxiety and stress. (R 16; ROA 275 to 278).

On June 6, 2007, Standard informed Cox (through his attorney) of its decision to uphold the benefit determination on appeal, thereby exhausting Cox's administrative remedies under ERISA. (R 16; ROA 82 to 68).

SUMMARY OF THE ARGUMENT

Cox, in his Appellate Brief, portrays his decision to cease practicing clinical medicine as compelled by life-or-death medical necessity. Cox claims that he had a migraine induced stroke on April 29, 2003, and that he is at grave risk of having another stroke with every migraine event. He describes his risk of stroke with dramatic hyperbole. He laments the "great risk" and "significant danger" that he

will have a "potentially disastrous," "catastrophic" or even "fatal" stroke unless he stops working. (App. Br., pgs. 1-3, 17, 34).

Cox portrays the individuals at Standard, on the other hand, as though they are grotesque characters in a novel by Charles Dickens. Cox is particularly vicious in his personal attack upon the claims and appeal specialists employed by Standard. Cox accuses Standard of masterminding a scheme to steer the inquiry away from the "true basis" for his disability claim (the alleged "high risk" of a "catastrophic" or "fatal" stroke) toward a "straw man issue" completely manufactured by Standard (the issue of cognitive deficits). The pervasive theme of Cox's Appellate Brief is that Standard intentionally derailed his disability claim by focusing on a sham issue, while turning a blind eye to the high risk that he might have another potentially deadly stroke. (R 28; ROA 1608, 1613).

It is interesting that the attorney who authored Cox's Appellate Brief also authored Cox's September 8, 2006 letter to Standard requesting an administrative appeal. (R 16; ROA 369 to 350). But in that letter of appeal, Cox's attorney never said that Standard ignored or failed to evaluate the true basis for Cox's disability claim; nor did he declare that the issue of cognitive deficits was a straw man. To the contrary, his letter of appeal emphasized Cox's claim of ongoing cognitive problems caused by a purported stroke, including "memory difficulties" and "concentration difficulties." (R 16; ROA 360, 371). Obviously Cox's argument

that Standard concocted a straw man issue and ignored the risk of stroke is completely disingenuous, because Cox's attorney never leveled these accusations against Standard in his letter requesting an administrative appeal. Claimants under ERISA may not convert their disability claims into moving targets, by asserting new arguments in federal court that they failed to assert during the administrative proceedings.

Standard, in fact, determined that the objective medical evidence failed to substantiate Cox's claim of a disabling stroke. Cox obviously was not at high risk of sustaining another stroke, because he never had a stroke in the first instance. Standard made this determination reasonably, by evaluating all of the medical evidence in depth, including the arterial angiogram and the history of Cox's MRI scans over a period of several years. Standard consulted two highly qualified neurologists, Drs. Zivin and Dickerman, both of whom opined that the MRIs and angiogram failed to support Cox's claim of a stroke. Dr. Hanks's extensive neuropsychological testing established that Cox has no cognitive deficits whatsoever, which itself is a remarkable finding for someone who claims to have suffered a life-threatening stroke that caused permanent brain damage.

This is not a case in which the administrator's decision is "overwhelmed by contrary evidence." Rather, Cox provided only the *ipse dixit* opinion of one treating physician, Dr. Voci, which in turn was contradicted by the objective

medical evidence. Standard "articulated a satisfactory explanation for its action, including a rational connection between the facts found and the choice made." *Motor Vehicle Mfrs. Ass'n v. State Farm Mut. Auto. Ins.*, 463 U.S. 29, 43 (1983). Accordingly, the district court's entry of judgment in favor of Standard and the Plan should be upheld.

STANDARD OF REVIEW

The district court's decision granting judgment for Standard and the Plan is reviewed on appeal *de novo*. See *Killian v. Healthsource Provident Administrators, Inc.*, 152 F.3d 514, 520 (6th Cir. 1998). The district court's determination of the standard of judicial review also is reviewed on appeal *de novo*. *Haus v. Bechtel Jacobs Co., LLC*, 491 F.3d 557, 561 (6th Cir. 2007).

A denial of benefits challenged under §502(a)(1)(B) of ERISA is to be reviewed under a *de novo* standard unless the benefit plan grants discretionary authority to the administrator. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989). When the plan documents contain discretionary language, however, courts review the administrator's benefit determination by applying the deferential "arbitrary and capricious" standard. *Id.* See also *Metropolitan Life Ins. Co. v. Glenn*, 128 S.Ct. 2343, 2348 (2008); *Haus*, 491 F.3d at 561. It is undisputed that the Group Policy grants discretionary authority to Standard, and that Standard's benefit decision was properly reviewed by the district court, and is

properly reviewed on appeal, pursuant to the arbitrary and capricious standard. (R 16; ROA 1444 to 1443; App. Br., pgs. 20-21).

The arbitrary and capricious standard is the least demanding form of judicial review. *Davis v. Kentucky Finance Cos. Retirement Plan*, 887 F.2d 689, 693 (6th Cir. 1989), *cert. denied*, 495 U.S. 905 (1990). An administrator's decision "will not be deemed arbitrary and capricious so long as 'it is possible to offer a reasoned explanation, based on the evidence, for a particular outcome.'" *Haus*, 491 F.3d at 561-562 (quoting *Davis*, 887 F.2d at 693). "When it is possible to offer a reasoned explanation, based on the evidence, for a particular outcome, that outcome is not arbitrary and capricious." *Evans v. UnumProvident Corp.*, 434 F.3d 866, 876 (6th Cir. 2006) (quoting *Killian*, 152 F.3d at 520; *Perry v. United Food & Commercial Workers Dist. Unions 405 & 442*, 64 F.3d 238, 241 (6th Cir. 1995)).

ARGUMENT

I. Standard Reasonably Determined That Cox Was Not At "High Risk" Of A "Potentially Deadly" Stroke.

Whether the risk of future disability constitutes a present disability depends on the probability of that risk's occurrence. Cox contends that he was at high risk of having a potentially fatal stroke if he continued working, but that Standard simply dismissed his decision to cease working as merely prophylactic. Cox argues that Standard performed the same flawed analysis that the district courts found to be arbitrary and capricious in *Lasser v. Reliance Standard Life Ins. Co.*,

146 F.Supp.2d 619 (D.N.J. 2001), *aff'd*, 344 F.3d 381 (3rd Cir. 2003), *cert. denied*, 541 U.S. 1063 (2004), and *Pompe v. Continental Casualty Co.*, 119 F.Supp.2d 1004 (W.D. Mo. 2000). The administrators in *Lasser* and *Pompe* determined that even a high risk of medical complications cannot be disabling until those complications actually occur. Cox asks to court to redress Standard's decision-making by formally adopting the "common care and prudence rule."

But Standard did not reject the idea that a high risk of disability can never be disabling. Rather, Standard determined that Cox never had a stroke. Cox was not at risk of another "potentially deadly" stroke because he never had a stroke in the first place.

Cox ascribes Standard's determination of "no stroke" to a *post hoc* rationalization cobbled together during the litigation by Standard's counsel. Cox presented the same argument to the district court and it was rejected. Standard's March 23, 2006 determination letter and June 6, 2007 appellate determination letter recite at length the medical evidence establishing that Cox never had a stroke.

In the March 23, 2006 determination letter, Standard determined that the MRI reports "revealed no evidence of an intracranial hemorrhage, mass lesion or apparent acute infarct," and that Cox "never had a focal neurological deficit consistent with a previous area of stroke or ischemia." (R 16; ROA 691).

In the June 6, 2007 appellate determination letter, Standard stated that a CT scan taken on April 29, 2003 "showed no evidence to indicate acute hemorrhage," the MRIs showed "no abnormalities" and "no evidence of intracranial hemorrhage, mass lesion or apparent acute infarct," and that "none of the interpreting radiologists have indicated any major abnormality." Standard specifically advised Cox's attorney that the medical records "do not indicate that there is any significant underlying anatomic vascular abnormality in Dr. Cox's aortocranial circulation." (R 16; ROA 78, 72).

Cox nevertheless presses the court to adopt the common care and prudence rule, but in significantly modified form that conflicts with the law of ERISA. Cox's version of the common care and prudence rule would give *persuasive weight* to a treating physician's assessment of the risk of disability. Cox declares on page 35 of his Appellate Brief that "[t]his Court made it clear that an insurer should ordinarily not substitute the opinions of its own hired physicians for those of a claimant's treating physicians, and could never properly do so where the insurer's physicians did not persuasively outweigh the claimant's treaters." (App. Br., pg. 35). To support his proposition Cox cites *Hoover v. Provident Life and Accident Ins. Co.*, 290 F.3d 801 (6th Cir. 2002). *Hoover*, however, was decided under the *de novo* standard of judicial review. The court in *Hoover* determined that the

opinions of the plaintiff's treating physicians outweighed the opinions of the insurer's consulting physicians.

Cox's argument that the common care and prudence rule mandates that persuasive weight be given to the opinions of a claimant's treating physicians contravenes the Supreme Court's decision in *Black & Decker Disability Plan v. Nord*, 538 U.S. 822 (2003). The Court in *Nord* held that "[C]ourts have no warrant to require administrators automatically to accord special weight to the opinions of a claimant's physician; nor may courts impose on plan administrators a discrete burden of explanation when they credit reliable evidence that conflicts with a treating physician's evaluation." *Id.* at 834

Of course, *Nord* further holds that ERISA administrators "may not arbitrarily refuse to credit a claimant's reliable evidence, including the opinions of a treating physician." *Id.* But Standard did not *arbitrarily* reject the opinions of Cox's treating physician, Dr. Voci. To the contrary, the administrative record reflects legitimate questions about the reliability of Dr. Voci's opinion that Cox even had a stroke.

Dr. Voci was the *only physician* who endorsed Cox's disability claim. Dr. Voci wrote prolific "To whom it may concern" letters advocating on Cox's behalf. In those letters, Dr. Voci opined that Cox had a brainstem stroke based on an MRI obtained on April 29, 2003 and an angiogram obtained on April 30, 2003. Dr.

Voci opined that "the MRI showed a questionable aneurism of the posterior communicating artery" and that "[t]here may also have been some narrowing of the basilar artery." (R 16; ROA 582). Dr. Voci opined that the April 30, 2003 confirmed that Cox had a stroke.

Dr. Voci's diagnosis of a stroke, however, was inconsistent with the medical opinion of every radiologist who reviewed the angiogram and MRIs.

The radiologist that obtained the April 29, 2003 MRI, David Fry, M.D., found no evidence of a narrowing basilar artery: "There is cephalic flow in both visualized intracranial ICA's as well as the basilar artery and their major branches. No definite large aneurysm is identified." (R 16; ROA 410). Dr. Fry further opined "No abnormal vascular arterial structure seen." (R 16; ROA 410). Although Dr. Fry found some "focal prominence" in posterior communicating artery, he was of the opinion that this finding most likely reflected a normal structural variance called a "prominent infundibulum" rather than evidence of an aneurysm.[3] As stated in Dr. Fry's MRI report:

[3] A prominent infundibulum is a benign structural variance that arises in the developing fetus. It is a smooth funnel-shaped enlargement that occurs when a blood vessel in the developing fetus does not completely regress. The most frequent location of a prominent infundibulum is in the *posterior communicating artery*, which is the precise location of Cox's prominent infundibulum. See http://emedicine.medscape.com/ article/252142-overview. The American Journal of Neuroradiology reports that a prominent infundibulum can give the false impression of a posterior communicating artery aneurysm. http://www.ajnr.org /cgi/reprint/28/1/60.pdf.

> Impression:
> There are findings at the level of the left P. [pituitary] comm. [communicating artery] which I think probably is related to a prominent infundibulum but his area is notoriously difficult to be sure, especially on MRA.

(R 16; ROA 410). Dr. Fry recommended an angiogram in order to "rule out [a] small aneurism at this site." (R 16; ROA 410).

The April 30, 2003 angiogram, in turn, was completely normal. As stated by Thomas Barbieri, M.D., the radiologist who obtained the angiogram:

> Arch aortography demonstrates patency of the great vessels, including the right subclavian, right vertebral, right common carotid, left common carotid and left subclavian arteries. The left vertebral artery is not shown.
> Selective right common carotid angiogram shows the right common carotid artery to be widely patent. The bifurcation is widely patent. Intracranially, there is no evidence of neovascularity, abnormal tumor stain or early draining vein or aneurysm formation.
>
> Left common carotid angiogram shows no evidence of neovascularity, abnormal tumor stain or early draining vein. Left subclavian angiogram show the left subclavian artery to be widely patent. The left vertebral artery is not shown.
>
> Selective right vertebral angiography show no evidence of neovascularity, abnormal tumor stain or early draining vein.
>
> **IMPRESSION(S):**
> Unremarkable cerebral angiography except the left vertebral artery is not demonstrated.

(R 16; ROA 480). Even Dr. Voci, in his May 1, 2003 hospital discharge summary, correctly acknowledged that the radiographic evidence "failed to identify any

ischemic changes to the brain stem region" and that "[a] transcranial Doppler study here showed no absence of flow throughout any of the posterior circulation." (R 16; ROA 484 to 483).

One week later, however, *after* Cox submitted a disability claim, Dr. Voci's medical opinion abruptly changed, even though Dr. Voci neither conducted any additional tests nor performed a follow-up examination. On May 9, 2003, Dr. Voci signed an APS in which he opined that Cox was disabled due to "vertebral basilar thrombosis / ischemia." (R 16; ROA 381). Dr. Voci's opinion in the May 9, 2003 APS clearly is inconsistent with his opinion in the May 1, 2003 hospital discharge summary that Cox had no ischemic changes to the brain stem region.[4]

A second MRI obtained on May 31, 2003 and evaluated by radiologist Harold Panson, M.D. also was completely normal and unchanged from the April 29, 2003 MRI. As stated by Dr. Panson on the MRI report:

> There is no evidence suggesting supratentorial or infratentorial masses. On diffusion-weighted imaging *no abnormal signal is evident*. Post gandolinium imaging shows no abnormal enhancement.

[4] On the May 9, 2003 APS, Dr. Voci listed extreme limitations in Cox's ability to stand, sit or walk due to an ischemic stroke. Dr. Voci opined that Cox cannot stand for more than one hour at a time, walk for more than one hour at a time, or sit for more than three hours at a time. (R 16; ROA 380). Dr. Voci's extreme limitations have absolutely no support in the administrative record. Not even Cox contends that he cannot sit for more than three hours, walk for more than one hour, or stand for more than one hour due to the risk of having a stroke.

(R 16; ROA 408) (emphasis added).

In direct contradiction with Dr. Panson's findings that there were no abnormal signals evident, Dr. Voci wrote another "To whom it may concern" letter to Standard dated July 21, 2003 in which he opined that the May 31, 2003 detected abnormal signals consistent with a stroke:

> An MRI Scan of the brain was eventually performed on 05-31-2003. This revealed changes in areas of *abnormal signal* consistent with ischemic infraction of the brain stem and left cerebellum. This was consistent with the cerebral angiographic findings as well as the clinical history.

(R 16; ROA 385). Dr. Voci's opinion in his "To whom it may concern letter" is contradicted by the findings of Dr. Panson's MRI.

The only radiologist to acknowledge any possible abnormal brain activity was Peter Nefcy, M.D, one of Dr. Voci's employees. In his January 30, 2004 MRI report, Dr. Nefcy stated: "[a] small amount of abnormal signal intensity is seen in the upper brain stem bilaterally, suggesting some ischemic changes." (R 16; ROA 405). Based on Dr. Nefcy's MRI, Dr. Voci wrote another "To whom it may concern" letter, dated February 16, 2004, in which he opined that Cox sustained a "cerebrovascular ischemic insult to the brain stem and cerebellum" and that Cox was disabled due to the risk of further stroke. (R 16; ROA 389).

On February 4, 2005, however, Dr. Nefcy performed a repeat MRI, which detected the same minor signal abnormality reflected in the January 30, 2004 MRI.

But this time, Dr. Nefcy was equivocal about the significance of that finding: "A small amount of mildly abnormal signal intensity is seen in the upper brainstem bilaterally, which is unchanged. The exact significance is uncertain." (R 16; ROA 403).

A repeat MRI obtained by Frank Fayz, M.D. on November 3, 2005, also detected this minor abnormal signal intensity. Dr. Fayz concluded that this finding was completely benign and stable: "Stable benign type linear signal changes bilateral midbrain." (R 16; ROA 399). Dr. Fayz's medical assessment correlates with the medical assessment of Dr. Fry, who opined that the signal changes shown on the April 29, 2003 MRI most likely reflected a completely normal "prominent infundibulum" rather than evidence of an aneurysm.

The inconsistencies between Dr. Voci's opinions in his "To whom it may concern" letters that Cox was at grave risk of further stroke, and, on the other hand, the objective evidence establishing that Cox never had a stroke, was not lost on Drs. Zivin and Dickerman, the neurologists consulted by Standard. Drs. Zivin and Dickerman astutely determined that Dr. Voci's opinion of permanent disability due to a purported risk of stroke was completely unsupported by the objective medical evidence.

Cox, in his Appellate Brief, argues that the administrative record fails to identify the records provided to Dr. Dickerman for review. Standard's referral

request to Dr. Dickerman, however, expressly requests review of the records of Dr. Voci, Michigan Sleep Consultants and Bon Secours Hospital. (R 16; ROA 926). Dr. Dickerman's September 19, 2005 Physician Consultant Memo specifically references these medical records, including the radiologists' reports of the MRIs obtained on May 31, 2003, January 30, 2004, and February 4, 2005. (R 16; ROA 915 to 913).[5]

Dr. Dickerman candidly noted that the records from Cox's April 29, 2003 hospitalization (namely, the April 29, 2003 MRI and April 30, 2003 angiogram) were not available for review. (R 16; ROA 913). Dr. Hanks, too, in her Independent Neuropsychological Evaluation, noted the absence of these records. (R 16; ROA 795). In his Appellate Brief, Cox accuses Standard of failing to request these records out of neglect. Standard, however, expressly requested Dr. Voci to produce "[a] copy of all clinical records (chart notes, health history statements, lab/x-ray/scan results, consult reports, referrals, other insurance information)" for the period "January 1, 2002 to Present." (R 16; ROA 1346).

Standard, moreover, provided Cox with a copy of Dr. Hanks's report together with its March 23, 2006 determination letter, thereby notifying Cox of the

[5] Dr. Dickerman subsequently reviewed the results of Dr. Hanks's neuropsychological testing and the surveillance video, as reflected in his March 8, 2006 Physician Consultant Memo. (R 16; ROA 722 to 720).

absence of the April 29th hospitalization records. (R 16; ROA 694).[6] Thus, Cox and his attorney were well aware that the April 29th hospitalization records had not been provided to Standard. Having been duly notified, Cox's attorney submitted the missing hospitalization records to Standard for review as part of his administrative appeal. (R 16; ROA 490 to 479; ROA 369 to 350).

Standard, therefore, provided all of Cox's medical records, including the April 29th hospitalization records, to neurologist Dr. Zivin for review. Dr. Zivin opined that Dr. Voci's diagnoses of a basilar stroke and left vertebral artery thrombosis were unsupported by the April 29, 2003 MRI and the April 30, 2003 angiogram:

> This [angiogram] was an arch aortogram, which includes intracranial views of the carotid vessels; the right vertebral system was open, the left subclavian was open, but there was no visualization of left vertebral artery. There are no comments by the reading of performing radiologist relative to any abnormality of a basilar artery itself, nor are there references to any branches of vertebral arteries on either side. No aneurisms, tumor stain or mass effect are reported in this or any of the other studies of the date above. Nevertheless, it appears that neurologist Voci felt that there was ischemic change in the brainstem and cerebellum by his apparent personal review of the angiogram. This is not reflected in any further reviews of radiographic features contemporaneously.

(R 16; ROA 283 to 282).

[6] In addition, on March 13, 2006, Standard provided Cox's attorney with Dr. Dickerman's and a second copy of Dr. Hanks's reports, as well as the entire administrative record. (R 16; ROA 682).

Dr. Zivin opined that the purported abnormal findings on the MRI scans reflected merely normal structural variances, which is consistent with Dr. Fayz's conclusion that the signal changes in the brain were "stable" and "benign" and Dr. Dr. Fry's assessment that the signal changes merely reflected a "prominent infundibulum." (R 16; ROA 285).

Cox argues that Standard's undersigned counsel led the district court to believe that Drs. Dickerman and Zivin viewed the actual MRI and angiogram images rather than the radiologists' report, and that the district court somehow was "fooled." (App. Br., pg. 31). During the July 14, 2008 hearing, Standard's counsel clearly advised the district court that Drs. Dickerman and Zivin reviewed the radiologists' reports. (R. pg. 19; ROA 43). Cox's contention that the district court was misled is baseless.

Every physician who reviewed the actual MRI and angiogram images—with the exception of Dr. Voci—ultimately concluded that Cox did not have ischemia, arterial thrombosis or a stroke. It appears, therefore, that Dr. Voci was acting more as Cox's disability advocate than as a treating physician rendering objective medical opinions. See *Nord*, 538 U.S. at 832 (acknowledging the well known propensity for treating physicians to act as disability advocates); *Davis v. Unum Life Ins. Co. of America*, 444 F.3d 569, 578 (7th Cir.), *cert. denied*, 549 U.S. 884 (2006) (observing that the treating physician acted "more as an advocate than a

doctor rendering objective opinions"); *Hawkins v. First Union Corp. Long Term Disability Plan*, 326 F.3d 914, 917 (7th Cir. 2003) ("[P]hysicians naturally tend to support their patients' disability claims, and so we have warned against 'the biases that a treating physician may bring to the disability evaluation….'") (quoting *Dixon v. Massanari*, 270 F.3d 1171, 1177 (7th Cir. 2001)).

II. Standard Reasonably Determined That Cox Was Not Disabled Due To Cognitive Deficits.

Cox alleges that Standard created a "straw man" issue of "cognitive deficits" in order to derail his disability claim. (App. Br., pgs. 17, 27). Cox falsely represented to the district court that he never "asserted or even suggested" any neurocognitive impairment as a factor contributing to his claimed disability. (ROA 28, pg. 8). Cox now makes the same false representation to the Sixth Circuit. According to Cox, the issue of cognitive deficits was a sham devised by Standard to divert attention from his true basis for seeking disability benefits, namely, the high risk of another potentially deadly stroke.

In his September 8, 2006 letter requesting an administrative appeal, however, Cox's attorney never stated that the issue of cognitive deficits was a straw man, or that Standard ignored or simply dismissed his risk of stroke. To the contrary, the letter of appeal emphasized Cox's claim of ongoing neurological symptoms purportedly caused by the April 29, 2003 "ischemic event," including "concentration problems," "residual deficits," "memory difficulties" and "fatigue."

(R 16; ROA 361 to 358). Cox, in fact, repeatedly complained to Standard about cognitive deficits purportedly caused by his stroke. On September 30, 2003, Cox told Standard that his photographic memory was "now shot" and that tasks he used to perform in one hour now take four to five hours to perform. (R 16; ROA 1327). In a letter to Standard dated April 21, 2005, Cox again emphasized memory loss, difficulty concentrating, and a loss of executive functioning due to brain damage from his purported stroke. (R 16; ROA 1081).

Given these complaints of impaired cognitive functioning, Standard acted reasonably by obtaining a neuropsychological IME in order to validate Cox's subjective complaints. Even during the neuropsychological examination, Cox claimed that he "had difficulty with memory, with reading comprehension, and organization." (R 16; ROA 800). The neuropsychological testing objectively established that Cox had no cognitive impairment whatsoever. (R 16; ROA 799).

Standard, therefore, did not "manufacture" the issue of cognitive deficits as a straw man. Standard's evaluation of Cox's cognitive complaints reflected responsible decision- making. See *Wical v. Intern. Paper Long-Term Disability Plan*, 191 Fed.Appx. 360, 372 (6th Cir. 2006) (holding that it was reasonable for an administrator to rely on the findings of an IME); *Leipzig v. AIG Life Ins. Co.*, 362 F.3d 406, 409 (7th Cir. 2004) ("Most of the time, physicians accept at face value what patients tell them about their symptoms; but [administrators] must consider

the possibility that applicants are exaggerating in an effort to win benefits (or are sincere hypochondriacs not at serious medical risk).").

III. Standard Reasonably Determined That Cox Was Not Disabled Due To Migraine Headaches.

The radiographic evidence establishes that Cox did not have a stroke or ischemic event. The neuropsychological testing and sleep study establish that Cox did not have any cognitive deficit or debilitating sleep disorder. What remains of Cox's disability claim, therefore, is his complaint of occasional migraine headaches. Drs. Dickerman and Zivin reasonably determined that Cox experiences common migraine symptoms, but that these are temporary symptoms and would not preclude Cox from gainful employment.

The administrative record reflects that when Cox experienced a severe or persistent migraine, he went to the emergency room in order to obtain intravenous steroids and pain medication. After the purported stroke on April 29, 2003, Cox did not return to the hospital for treatment of a migraine until nearly one year later, on March 23, 2004. (R 16; ROA 494 to 492). At that time, Cox received intravenous steroids and pain medication, and his headache resolved after two hours. Cox was discharged three hours after arriving at the hospital. Cox's history of medical treatment for migraine headaches after March 23, 2004 is summarized below:

(i) December 7-8, 25-27 2004: On December 7, 2004, Cox received pain medication for a migraine and was discharged three hours later. Because his migraine had not fully resolved, he returned the following morning for further treatment and was discharged in the late afternoon. (R 16; ROA 515 to 514). Cox had another migraine on the evening of December 25, 2004, and at 9:26 pm, he returned to the emergency room for pain medication. (R 16; ROA 563 to 562). Dr. Voci admitted Cox for observation, and he was discharged the following morning. (R 16; ROA 582 to 581).

(ii) Cox did not require medical attention for a migraine between December 2004 and December 2006, even though in August 2006, Cox and his family moved to Florida.

(iii) December 8-10, 2006: During a visit to Michigan on December 8, 2006, Cox returned to Bon Secours for treatment of a migraine. (R 16; ROA 264 to 204). Dr. Voci admitted Cox for observation for one day. (R 16; ROA 221).

(iv) After returning to his home in Florida, on December 25, 2006, Cox went to the North Florida Regional Medical Center for treatment of a migraine. (R 16; ROA 201 to 191). He received a course of steroids, pain medication, and was discharged after approximately two hours. Cox refused the attending physician's recommendation of a CT scan of the brain: "CT of the head was ordered. The patient, however, refused it, he states he knows his body and that he is a physician. He does not think he needs to have a CAT scan done here because this is his typical migraine, so this was refused." (R 16; ROA 198).

After his April 29, 2003 claimed date of disability until June 2003, when the administrative record closed, Cox experienced only four migraine events that were sufficiently severe or persistent to require medical attention.[7] An average of one

[7] Dr. Voci opined that Cox should avoid potential triggers for migraines such as fluorescent lighting. (R 16; ROA 1357 to 1356). But in a separate piece of litigation, Cox attributed the cause of his April 29, 2003 migraine to the medication Vioxx, which he was taking in 2003 due to a neck injury, and not to fluorescent

migraine per year clearly would not preclude Cox from working as a family physician, a medical researcher and teacher, or in any other occupation.

IV. Standard's Reasonable Decision Does Not Become An Arbitrary And Capricious Decision Based On *Glenn*.

Although Cox acknowledges that the deferential "arbitrary and capricious" standard of review applies, he nevertheless argues that the Supreme Court's decision in *Glenn* warrants close scrutiny of Standard's benefit decision. (Pl. App. Br., pg. 21). *Glenn* holds that when a single entity is responsible for deciding benefit eligibility and paying eligible claims, an inherent conflict of interest exists. *Metropolitan Life Ins. Co. v. Glenn*, 128 S.Ct. 2343, 2346 (2008). The Court, however, refused to compensate for an administrator's conflict by altering the standard of review. *Id*. (citing *Firestone*, 489 U.S. at 111-115). Rather, a conflict of interest is one of many factors for the court to consider in evaluating whether the administrator's decision was arbitrary and capricious. *Id.* at 2350. The conflict might act as a "tie-breaker" when all the other factors are closely balanced, or the significance of the conflict might diminish to the vanishing point depending upon the particular facts of the case. *Id.*

Most of the arguments offered by Cox as evidence of a conflict already have been addressed and refuted in this brief. Standard did not manufacture the issue of

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lighting. See http://www.foxnews.com/story /0,2933,152224,00.html. (R 16; ROA 793). Cox, moreover, was shown on surveillance video shopping in a mall illuminated with fluorescent lighting without any distress.

cognitive deficits as a straw man. Nor did Standard ignore Cox's claim that he was at high risk of another potentially deadly stroke. Standard evaluated the clinical and objective medical data, consulted two neurologists, conducted a neuropsychological IME of Cox, and reached a reasonable decision that was supported by substantial evidence.

Cox argues that Standard's reliance on the opinions of consulting neurologists somehow manifests a conflict of interest. The Sixth Circuit has held that there is "nothing inherently objectionable about a file review by a qualified physician in the context of a benefits determination." *Calvert v. Firstar Finance, Inc.*, 409 F.3d 286, 296 (6th Cir. 2005). As articulated in *Smith v. Health Services of Coshocton*, No. 08-3620, 2009 WL 481603, at *10 (6th Cir. Feb. 25, 2009):

> Where we have found a file review to support a determination that an administrator's decision was arbitrary and capricious, the review has been conducted by a doctor employed by the plan administrator who based his decision on selected portions of the administrative record or whose findings were inherently inconsistent or contradicted objective medical findings.

(Citing *Moon v. UnumProvident Corp.*, 405 F.3d 373, 374-378 (6th Cir. 2005)).

The neurologists consulted by Standard, Drs. Zivin and Dickerman, are not employed by Standard; they have expertise in neurology; they served as professors of medicine and maintained active clinical practices treating patients; and they based their opinions on the relevant medical evidence contained in the administrative record. The opinions of Drs. Zivin and Dickerman were consistent

with the opinions of every physician who actually reviewed the MRI scans and angiogram, with the exception of Dr. Voci.

While ERISA administrators should strive to provide a full and fair review that is unflawed, perfection can seldom if ever be achieved. This case is no exception. That is why ERISA requires substantial compliance, rather than strict compliance, with ERISA's procedural due process requirements. *Smith*, 2009 WL 481603, at *6. Standard's March 23, 2006 determination letter and June 6, 2007 appellate determination letter do not specifically address the SSA's finding in Cox's favor. Perhaps the SSA, applying the treating physician rule, deferred to Dr. Voci's diagnosis of a stroke and opinion that Cox sustained impaired cognitive functioning secondary to a stroke. Or perhaps the SSA, unlike Standard, did not seek the opinion of an independent neurologist or conduct any neurocognitive testing. The SSA's rationale is unknown because Cox submitted only the SSA's notice of award letter to Standard. Standard has a fiduciary obligation under ERISA to consider the relevant evidence and to provide Cox with a full and fair review of his disability claim. But disability claimants also bear some responsibility for submitting evidence in support of their disability claims, particularly when the claimants, like Cox, retain their attorney of choice during the administrative review proceeding.

The factors that supported Standard's benefit decision were not so closely balanced that this case must be decided by resort to a tie-breaking conflict of interest. Standard's determination that Cox did not have a stroke and sustained no stroke related cognitive deficits was supported by substantial evidence. Consideration of a conflict of interest, therefore, does not transform Standard's reasonable benefit decision into an arbitrary and capricious decision. See *Smith*, 2009 WL 481603, at *11 ("[W]e must still decide whether the record, as a whole, supports a reasoned explanation for the plan administrator's decision. [A]pplying *Glenn*, we have weighed Medical Mutual's conflict of interest as one factor in reviewing the decision. However, we conclude that the other factors are not closely balanced in this case given the support in the record for the Plan administrator's decision.") (internal citations omitted).

CONCLUSION

Although Cox experiences occasional migraine headaches, a condition that he has had for more than fifteen years, that condition did not prevent him from working as a physician, nor does it prevent him now from pursuing his true calling as a medical academic, writer and lecturer. Standard reasonably determined that Cox had not sustained a stroke, that he had no cognitive deficits, and that his long-standing history of occasional migraines were not disabling. Standard considered every aspect of Cox's medical condition, and consulted highly qualified physicians

who examined the clinical and objective medical evidence. Standard, therefore, properly exercised its discretionary authority by declining to pay further benefits to Cox. Accordingly, the judgment of the district court should be affirmed.

Respectfully submitted,

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Case No. 08-2033
UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

DAVID B. COX,	)	
	)	
Plaintiff - Appellant,	)	**U.S. District Court for**
	)	**Eastern District of Michigan**
	)	
	)	**No. 2:07-cv-13304**
v.	)	
	)	**Judge Anna Diggs Taylor**
STANDARD INSURANCE COMPANY;	)	
BON SECOURS-COTTAGE HEALTH	)	
SERVICES GROUP PLAN,	)	
	)	
Defendants - Appellees.	)	

CERTIFICATE OF COMPLIANCE

The undersigned, counsel of record for defendants-appellees, Standard Insurance Company and Bon Secours-Cottage Health Services Group Plan, pursuant to Fed. R. App. P. 32(a)(7)(C), that the Brief of the defendants-appellees complies with the type-volume limitation of Fed. R. App. P. 32(a)(7)(B) because this Brief contains 8,726 words and 818 lines including footnotes excluding the parts of the Brief exempted by Fed. R. App. P. 32(a)(7)(B)(iii). In addition, this Brief complies with the typeface requirements of Fed. R. App. P. 32(a)(5) and the type style requirements of Fed. R. App. P. 32(a)(6) because this Brief has been prepared in a proportionally spaced typeface using Microsoft Word 2003, Times New Roman font in 14 point size, with footnotes in 14 point size.

Respectfully submitted,

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	)	
Plaintiff - Appellant,	)	**U.S. District Court for**
	)	**Eastern District of Michigan**
	)	
	)	**No. 2:07-cv-13304**
v.	)	
	)	**Judge Anna Diggs Taylor**
STANDARD INSURANCE COMPANY;	)	
BON SECOURS-COTTAGE HEALTH	)	
SERVICES GROUP PLAN,	)	
	)	
Defendants - Appellees.	)	

CERTIFICATE OF SERVICE

I hereby certify that on the 6th day of May, 2009, I electronically filed the foregoing with the Clerk of the Court using the CM/ECF system, which will send notification of such filing to the following attorney of record:

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